EUROPEAN LEAGUE AGAINST RHEUMATISM
FRIDAY/SATURDAY EDITION

eular Congress News

9th Annual European Congress of Rheumatology • 11-14 June 2008 • Paris

Friday, 13 June

Registration	08:00–19:00
Exhibition	09:30–17:15
Scientific Sessions	10:15–17:00
EULAR Congress Dinner	20:30

10:15–11:45

Abstract Sessions

After TNF: new biologics — **Grand Amphi**

RA–clinical aspects and comorbidity — **Room Ternes**

Is treatment of OA feasible? — **Amphi Bleu**

Gout and metabolic bone disease — **Room Bagatelle**

A rash of new developments in PsA — **Amphi Bordeaux**

SLE, Sjögren's and APS: Aetiology, pathogenesis and animal models — **Room Monceau**

Periodic Fever: Take two aspirin, but you still call me in the morning — **Room Maillot**

Imaging of the rheumatic diseases — **Amphi Havane**

Scleroderma and myositis — **Room 252-AB**

Tighter-fitting genes: New frontiers in the genetics of rheumatic diseases — **Room 342-AB**

All the best: RA aetiology, pathogenesis and animal models — **Room 352-AB**

Education as part of treatment — **Room 241**

Rehabilitation — **Room 353**

Continued on page 16

Congress Dinner 2008

Please join your colleagues for an unforgettable evening. This year's Congress dinner has been conjured up as a fun fair to take place on three stages. In Les Salons du Musique, surrealist computerisation mixes vintage 1930s music with contemporary chimes. Le Musée des Arts Forains, a reconstruction of a mid-19th-century fair, offers rides, fair stalls, and attractions. Enter, if you dare, the "Felliniesque" world of Les Salons Vénitiens. The choice of which stage to enjoy is yours. Or cavort on each in turn.

Friday, 20:30–24:00
Les Pavillons de Bercy

EUR 140 per person for Buffet Dinner and Fun Fair Attractions

EULAR Delegates Welcomed During Wednesday's Opening Ceremonies

Attendees heard from several EULAR dignitaries, including President Breedveld, who discussed EULAR's strategic goals for 2012; scientific chair Prof. Berenbaum, who said this year's Congress has set new records the number of abstracts; local organising committee chair Prof. Euller-Ziegler, who welcomed everyone to Paris; and Mr. Maarten de Wit, vice president representing PARE.

Prof. Ferdinand C. Breedveld

Prof. Francis Berenbaum

Prof. Liana Euller-Ziegler

Mr. Maarten de Wit

Recipients of the EULAR Basic Science Abstract Awards are shown above with Prof. Breedveld (right).

Recipients of the EULAR Clinical Science Abstract Awards are shown above with Prof. Breedveld (right).

Cover photos © C. Peus

Patients With Systemic Sclerosis Should Have Screening for PAH

The incidence of pulmonary arterial hypertension in patients with systemic sclerosis is 0.61 per 100 patient-years, according to data on 384 patients in a longitudinal study to be presented Friday by Dr. Eric Hachulla.

The prevalence of pulmonary arterial hypertension (PAH) in a cohort of patients from the ItinerAir-HTAP registry, which is a 3-year, multicentre study of patients with systemic sclerosis, was found to be 7.85% (confidence interval range, 5.70-10.00), prompting this study to determine the incidence of PAH over 3 years of follow-up, explained Dr. Hachulla of Hôpital Claude Huriez, Lille (France).

Dr. Eric Hachulla

The patients underwent Doppler echocardiography screening for PAH. PAH was suspected in those with peak velocity of tricuspid regurgitation (VTR) of 2.8-3 m/sec and unexplained dyspnea, or with VTR greater than 3 m/sec, according to Dr. Hachulla.

Right heart catheterization (RHC) was used to confirm pulmonary hypertension.

The patients, 87% of whom

Continued on page 8

In OA, General Practitioners May Fall Short

Findings from a survey of general practitioners indicated that when managing patients with osteoarthritis of the knee, they often failed to distinguish inflammatory flares from mechanical pain, which resulted in inadequate treatment adjustments in patients with inflammatory symptoms, according to a study being presented here on Friday.

The main goal of the study was to focus not on what general practitioners prescribe for OA "but how they adapt or adjust treatment based on clinical symptoms," Prof. Xavier Chevalier, who will be presenting the results, said in an interview with *EULAR Congress News*.

Prof. Chevalier, who is a professor of medicine at the Université Paris XII and head of department of rheumatology at Hôpital Henri Mondor, Créteil (France), and his associates conducted the survey of general practitioners in France.

A total of 683 surveys were completed.

Continued on page 2

Letter from the Secretariat: Looking Forward

Dear Participants and Friends:

Let me extend a warm welcome to all of you who are attending this year's EULAR Congress in Paris. Our Congress programme committee, including scientists and clinicians, health professionals, and patient organisation representatives, has again established a most interesting top-notch programme. Over 330 invited speakers will be involved this year; more than 3,400 abstracts were submitted, reviewed, and selected for oral presentation, for discussion during the poster viewing sessions, or for inclusion in the official abstract book.

Mr. Heinz Marchesi

For the EULAR Executive Committee and the Secretariat, the last 12 months have been particularly exciting. As in previous years, EULAR has been strongly engaged in a broad range of activities in education, research, and clinical projects, international relations, and patient-oriented work. When perusing the Congress programme or reading *EULAR Congress News*, you will encounter many of the fruits of our activities: new recommendations, educational sessions, or networking efforts. What made last year special for us, however, was the fact that we were collectively thinking about our future.

A Year of Strategic Planning by EULAR

Under the leadership of EULAR President Prof. Ferdinand C. Breedveld, we have spent numerous hours in meetings and individual work to reflect where EULAR stands today and to set goals for where we want to go in the next 5 years. As EULAR continues to gain influence, we have more opportunities to make important contributions to rheumatic diseases. This good news also represents a challenge. To ensure ongoing success, we must be selective in what we do to maintain our highest standards. We want and need to focus our energy on what we consider the most urgent issues in the minds of rheumatologists, allied health professionals, politicians, and, above all, those affected by musculoskeletal conditions—the patients.

It was therefore a pivotal moment for EULAR early last year when a representative group of our Executive Committee met to define eight objectives for EULAR 2012 (see box). In the subsequent months, these objectives were distilled into a number of specific goals in key areas in which EULAR is engaged. These strategic areas are basically represented by our Standing Committees. Then, in September, a large representative group of experts from EULAR and neighbouring organisations met in Zurich to review and agree on the path that EULAR should pursue in the near future. Happily, the strategic planning effort has reinforced our beliefs and commitments. Over time, this effort has brought a diverse group of people closer together in a truly collaborative endeavour that involves nearly 100 scientists, doctors, allied health professionals, patients, industry representatives, and consultants from Europe as well as overseas.

The foundation for our next 5 years is laid. In the coming weeks and months, the Executive Committee and our Standing Committee chairmen will define the processes that will support us as we move on together to meet our objectives.

Of course, strategy is more than planning, defining, and reviewing. It is just as much an emotional process. That is why we have synthesised our strategic work in the following story line:

Mobilising the Planet—EULAR on its Way Towards 2012

EULAR gathers the most diverse and talented people in the rheumatology world. Many of our members have created the major advances in our field. Our scientists and doctors, together with our clinicians, health care professionals, patients, and supporting staff, have made extraordinary work possible.

Few disciplines have achieved so much change in recent years. Diseases are now modified. People experience mobility where before there was morbidity.

But how are we going to create the next major step? What's the best way to channel our efforts?

We've created a platform of eight places where we think effort could best be focussed. Some are purely medical, like finding new solutions to old diseases. Some are political: gaining awareness, recognition, and resources from the wider public. Others are more about how we work. We want to see more collaboration across professional bodies, and also international borders. We want our discipline to become the most attractive to young minds. After all, if we don't mobilise the planet, who will?

Enjoy EULAR 2008 Paris

In this spirit, all of us from the EULAR Secretariat wish you an exciting Congress with many opportunities to exchange ideas, learn about the latest developments in your fields, meet colleagues from all around the world, and, of course, have a good time in the unique city of Paris. To learn more about us and what we do, we also invite you to visit us at the EULAR booth for a chat. ■

Heinz Marchesi
Executive Director of EULAR

The Eight EULAR Objectives For the Year 2012

Every EULAR objective for 2012 follows the guiding principle that all EULAR activities will recognise the need for equity, access, transparency, and engagement.

1. By 2012, EULAR will have strengthened activities in areas that are currently lesser priorities, such as noninflammatory and orphan diseases.
2. By 2012, musculoskeletal diseases will be recognised as a priority and major disease area (reflected, for example, by research policy, disability legislation, and access to care).
3. By 2012, all EULAR stakeholders (e.g., people with arthritis, allied health professionals, practising clinicians, basic and clinical scientists, and industry) will have further strengthened their partnership.
4. By 2012, EULAR will have increased its international partnerships (such as those with the American College of Rheumatology, African League Against Rheumatism, European Medicine Agency, World Health Organization, Bone and Joint Decade, and European Union granting).
5. By 2012, EULAR will be the leading source for evidence-based expertise and opinion, and will have further fostered global thought leadership throughout the spectrum of musculoskeletal conditions.
6. By 2012, rheumatology will be among the most attractive specialties in medicine for young physicians and allied health professionals.
7. By 2012, EULAR will have brought on board high-quality contributors from the younger generation to take part in all EULAR activities.
8. By 2012, EULAR will have standards of care and fostered access to optimal care of people with musculoskeletal conditions in Europe.

What's a Flare?

OA *from page 1*

The survey questions pertained to a recent patient presenting for a consultation because of exacerbations in pain related to a known diagnosis of knee osteoarthritis (OA).

The French general practitioners were asked about the symptoms their patients were experiencing, but they were not directly asked whether they thought the patient had an inflammatory flare or mechanical pain.

Most (70%) of the patients were female, and 50% of them had bilateral involvement. A limp was the most common presenting symptom, reported in 82%; followed by mechanical pain in 75%; joint effusions in 37%; and nocturnal pain in 27%.

Signs of an inflammatory flare (including nocturnal pain and joint effusion) were reported in 12% of the patients. In the interview, Prof. Chevalier said that regardless of whether a patient's symptoms indicated a disease flare or purely mechanical pain, "the general practitioners' prescribing pattern was similar."

Prof. Chevalier also noted that a similar proportion of patients in each group received a prescription for paracetamol (acetaminophen) and for non-steroidal anti-inflammatory drugs (NSAIDs).

Of the patients with no nocturnal pain or joint effusion, 18% were given paracetamol, compared with 15% of those with one of these symptoms and 13% of patients with both of these symptoms.

NSAID therapy was prescribed for 25% of those with neither of these symptoms, compared with 20% of those with one of these symptoms and 19% of those with both of these symptoms.

These results suggest that general practitioners, at least in France, need to learn more about the symptoms of inflammatory flares and how to define a flare, according to Prof. Chevalier.

The survey responses also suggested that, despite existing EULAR guidelines that recommend regular exercise for patients with OA who are not experiencing flares, only 35% of those general practitioners surveyed said they prescribed physical therapy to patients.

In fact, physical therapy was prescribed more often in patients who had flares than in those who did not have flares (46% and 33%, respectively).

Another finding was that in about half of the cases, especially in those cases with nocturnal symptoms, the general practitioner recommended a local treatment for the patient, which in most cases was a corticosteroid injection. That is a good choice, Prof. Chevalier said.

But in about 20% of cases, the practitioners recommended an injection of hyaluronic acid, which is not appropriate treatment for a flare. Prof. Chevalier emphasised that these results needed to be interpreted with caution, because of the limitations of surveys.

The survey did not ask for information on the past medical history of the patients, nor whether the physicians increased NSAID doses. (The practitioners were asked only whether they stopped the medication or prescribed it de novo, he said, noting that increasing the NSAID dose would have been appropriate.)

The authors of the study said that they received no support from pharmaceutical companies. ■

Abstract Session:
Is Treatment of OA Feasible?
Friday, 10:15–11:45
Amphi Bleu

ORENCIA® therapy: as of 1st anti-TNF therapy in rheumatoid arthritis

ORENCIA: the next generation biologic

The first selective T-cell co-stimulation modulator

ORENCIA® (abatacept)

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ORENCIA® Prescribing Information

Presentation: Powder for concentrate for solution for infusion containing 250mg abatacept per vial. **Indication:** Treatment of moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, in adult patients who have had an insufficient response or intolerance to other DMARDs including at least one TNF inhibitor. A reduction in the progression of joint damage and improvement of physical function has been demonstrated during combination treatment with abatacept and methotrexate. **Dosage:** Treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA. Adult and elderly patients weighing < 60kg: 500mg (2 vials). Patients weighing ≥ 60kg ≤ 100kg: 750mg (3 vials). Patients weighing > 100kg: 1000mg (4 vials). See SPC for details of reconstitution and administration as a 30 minute infusion. After initial administration, Orencia should be given at 2 and 4 weeks, then every 4 weeks thereafter. Consider therapeutic alternatives if there is no response within 6 months. Use in children and adolescents not recommended. **Contraindications:** Hypersensitivity to the active substance or excipients. Severe and uncontrolled infections such as sepsis and opportunistic infections. **Warnings:** *Infections:* Treatment should not be initiated in patients with active infections. Caution should be exercised when considering the use in patients with a history of recurrent infections or underlying conditions which may predispose them to infection. Any patient who develops a new infection should be closely monitored and Orencia should be discontinued if a patient develops a serious infection. Screening for tuberculosis and hepatitis B should be performed prior to therapy. Monitor for signs of infection when transitioning from a TNF blocking agent to Orencia. *Allergic Reactions:* Caution in patients with a history of allergic reactions. *Malignancies:* The potential role of Orencia in the development of malignancies is unknown, see SPC. *Elderly:* Caution should be used when treating elderly patients due to a higher incidence of infections and malignancies in this patient group. *Autoimmune processes:* Theoretical risk of deterioration in autoimmune disease. Immunisation: Live vaccines should not be given concurrently or within 3 months of discontinuation of Orencia. Blood Glucose Tests: False elevations on day of infusion can occur, see SPC. **Drug Interactions:** Concurrent therapy with Orencia and a TNF inhibitor is not recommended. No major safety issues were identified with the use of Orencia in combination with sulfasalazine, hydroxychloroquine or leflunomide. **Pregnancy and Lactation:** Do not use in pregnancy unless clearly necessary. Women should use contraception and not breast-feed during treatment and up to 14 weeks after last dose. **Side Effects:** In placebo-controlled trials the most commonly reported adverse drug reactions included increased blood pressure, abnormal LFTs, headache, dizziness, cough, abdominal pain, diarrhoea, nausea, dyspepsia, rash, infections including LRTIs, URTIs, UTIs, herpes simplex and rhinitis, flushing, fatigue and asthenia. Uncommon but serious side effects included thrombocytopenia, leucopoenia, conjunctivitis, reduced visual acuity, basal cell carcinoma, hypotension, anxiety and depression. Hypersensitivity reactions were uncommon. In COPD patients, a greater percentage of abatacept than placebo treated patients developed a serious adverse reaction. See SPC for further details. **Legal category:** POM. **Marketing Authorisation Number:** EU/1/07/389/001. **Basic NHS Price:** 1 vial pack: £252.00. **Marketing Authorisation Holder:** Bristol-Myers Squibb Pharma EEIG, Uxbridge Business Park, Sanderson Road, Uxbridge, Middlesex UB8 1DH. For further information Tel: 0800-731-1736. **Date of PI Preparation: May 2007**

For further information or to request a copy of the SmPC, visit the Bristol-Myers Squibb exhibition stand at EULAR 2008. Alternatively, email your request to medical.information@bms.com

Bristol-Myers Squibb

Meet the EULAR Young Investigator Awardees

Each year, EULAR recognises three young investigators with awards (10,000 euros each) for exceptional research in the field of rheumatology. The awards were presented by Prof. Breedveld on Wednesday evening at the opening ceremony. EULAR asks that you join in congratulating this year's winners.


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William G. Dixon, Xenophon Baraliakos, and Fina Kurreeman with EULAR president Prof. Ferdinand Breedveld.

William G. Dixon, MSc, a clinical research fellow in the British Society for Rheumatology Biologics Register Arthritis Research Campaign epidemiology unit at the University of Manchester (England), achieved this honor from EULAR for his research, "Evaluation of the Safety of Anti-TNF Therapy in Patients With Rheumatoid Arthritis." He is a co-convener of the proposed EULAR Task Force on Biologics Registers, a member of the online Faculty of 1000 Medicine, and a EULAR abstract reviewer, in addition to his ongoing work in epidemiology, establishing the Clinical Research Fellows forum at his university, and writing for journals in the field. Dr. Dixon has submitted his doctoral thesis: "Respiratory Outcomes in Rheumatoid Arthritis." He plans to pursue a career in clinical academic rheumatology with an emphasis on drug safety. His next planned research project is on rheumatoid arthritis-associated interstitial lung disease.

Xenophon Baraliakos, MD, from the Rheumazentrum Ruhrgebiet in Herne, the academic hospital of the Ruhr-Universität Bochum (Germany), received the EULAR award in recognition of his research, "The Natural Course of Radiographic Progression in Ankylosing Spondylitis: Evaluation and Characterisation by Using Conventional Radiographs." Dr. Baraliakos plans to continue this line of research with a more detailed study of the usefulness of imaging in the characterisation of patients with ankylosing spondylitis. Specifically, he plans to use imaging to describe the early stages of the disease, perhaps resolving whether any inflammatory changes in AS predict its radiographic progression.

Fina Kurreeman, PhD, who is a member of the rheumatology faculty at Leiden (the Netherlands) University Medical Center, has been recognised as a EULAR Young Investigator this year for her research, entitled: "The Identification and Functional Characterisation of the Novel Genetic Risk Factor TRAF1/C5 in Rheumatoid Arthritis." She plans to begin her postdoctoral research at Leiden, with Prof. Tom Huizinga, by studying the functional characterisations of the TRAF1/C5 locus. Another research project on her agenda involves looking at other genetic risk factors for rheumatoid arthritis, such as structural variants.

EUSTAR Chair Describes Future Research Projects

In the year since the renewal of the board in Barcelona, EUSTAR has launched three important projects, supported by EULAR, in order to increase the awareness of scleroderma and to foster the study and early diagnosis of the disease, as well as to improve the education and the care of patients through evidence-based strategies, reported Prof. Marco Matucci Cerinic, chairman of EUSTAR.

"The first project was to transform the original database, called Minimal Essential Data Set (MEDS), into an online database called MEDSonline," stated Prof. Alan Tyndall, Secretary of EUSTAR, and Prof. Ulrich Walker, chairman of the Database Committee. MEDSonline will include prospective datasets on all sequential patients attending scleroderma clinics in Europe and elsewhere around the globe. "Having such a readily accessible online database will allow researchers to track special subgroups of systemic sclerosis (SSc) patients for later studies," stated Prof. Tyndall. Over the past 4 years, more than 7,000 patients have been registered with followups in MEDS. This resulted in publications addressing the main results obtained by the preliminary analysis of the data (Tyndall et al Ann Rheum Dis 2005;64:1107 & Walker et al Ann Rheum Dis 2007;66:754), and showed the interesting finding of centre differences rather than geographic clinical patterns of SSc in Europe (Walker U et al, Ann Rheum Dis in press).

Further analyses are in preparation, including analyses on myocardial dysfunction, pulmonary artery hypertension, erectile dysfunction, arthritis, incident digital ulcer patterns, the use of anti-TNF-alpha, and details on causes of death.

The early diagnosis of scleroderma is now a pivotal issue for EUSTAR. A project on Very Early Diagnosis of Systemic Sclerosis (VEDOSS) will be launched this year during the business meeting scheduled for Saturday, 08:00 in Room 242. Initially, the project will involve the creation of scleroderma clinics devoted to the early diagnosis of the disease throughout Europe.

The Basic Science Committee has finalised guidelines on cell culture and fostered the publication of papers on shared EUSTAR projects. Moreover, "the project of biobanking, supported by EULAR, is under preparation and will be launched at next year's EULAR Congress in Copenhagen," stated Prof. Oliver Distler, chairman of the Basic Science Committee.

The EUSTAR commitment on education conducted two courses, one in 2005 and another in 2007, organised by Prof. László Czirják, board member, and Prof. Ulf Müller-Ladner, treasurer of EUSTAR; each course was attended by 90 advanced trainees and 30 teachers.

The next course that will take place next January in Paris under the direction of Prof. Yannick Allanore.

During the course, "the correct approach to skin scoring techniques using real patients will be presented together with real application on scleroderma patients," said Prof. Czirják and Prof. Dan Furst, organisers of the skin scoring session.

In addition, the united patient self-help groups, called the Federation of European Scleroderma Associations (FESCA), represented by Kim Fligelstone and Anne Tyrrel Kennedy, are active partners in EUSTAR. They are participants at every level, to the mutual benefit of all.

Thanks to a very generous grant from EULAR through ESCISIT, a task force of European, North American, and Japanese colleagues, together with patient representatives (FESCA), completed a recommendation consensus process concerning the drug treatment of SSc. The set of recommendations presented last year in Barcelona will be published in the Annals of Rheumatic Diseases before the end of the year.

Meritorious Service Awards

The winners of the 2008 EULAR Meritorious Service Awards are two distinguished rheumatologists recognized for their years of research and patient care: Prof. Gabriel Panayi, of Guy's Hospital, London (left), and Prof. Thomas L. Vischer, Hôpital Cantonal Universitaire, Geneva, retired, past president of EULAR (right) are shown with EULAR President Prof. Breedveld (center).


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Bone Erosion and Low Bone Mass May Be Linked in PsA

A significant association between low bone mass and bone erosions in psoriatic arthritis suggests there is a relationship between the two types of bone loss in patients with this disease, judging from data to be presented Friday by Dr. Allen Anandarajah.

To assess a possible association between osteoporosis/osteopenia and bone erosions, Dr. Anandarajah used data on 1,456 patients with psoriatic arthritis (PsA) from the Consortium of Rheumatology Researchers of North America (CORRONA) database, the largest independent database in North America collecting clinical information on patients with rheumatologic disorders.

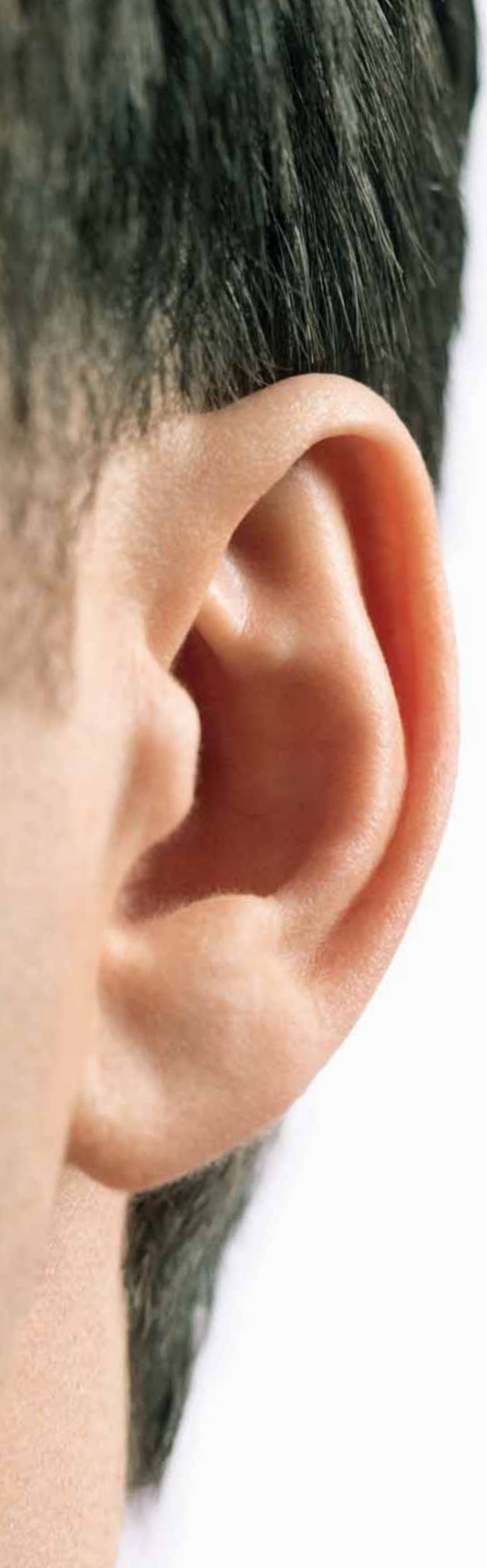
In an interview with *EULAR Congress News*, Dr. Anandarajah said that several studies have found that bone erosions are nearly as common in PsA as in RA. Recent studies have found that patients with PsA also often have low bone mass.

"People who had erosions were more likely to have low bone mass," compared with those who don't have bone erosions, said Dr. Anandarajah, clinical director of the allergy, immunology, and rheumatology unit at the University of Rochester, New York (USA). The study looked at the association between T scores at the lumbar spine and the presence or absence of erosions, adjusting for the steroid use, gender, methotrexate use, other disease-modifying antirheumatic drug use, and the use of biologics, as well as for weight, age, body mass index, and disease index.

Of the patients, 567 (40%) had erosions and 889 (60%) had no erosions. The mean age of patients with erosions was 42 years, significantly younger than the patients who had no erosions, whose mean age was 45. Significantly more men (52%) had erosions than did women (49%).

The association between the presence of bone erosions and lower T scores of the lumbar spine was significant, with significantly lower T scores of the lumbar spine among patients with erosions, compared with those who had no erosions.

Abstract Session:
A Rash of New Developments in PsA
Friday, 10:15–11:45
Amphi Bordeaux



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Our interactive response mechanism

At Schering-Plough, we believe that the greatest insights come not from technology but from the age-old wisdom of lending one's ears. We don't just listen to you but reflect on everything you say. It's this common sense that has not only helped Schering-Plough respond better to you and your patients' needs but has also helped us achieve truly inspired results in the field of rheumatology research, development and patient care.

Our experience shapes brighter futures

Schering-Plough

Your chance to be interactive:

EULAR 2008 Satellite Symposia, sponsored by Schering-Plough

Interactive anti-TNF meeting revolves around our satellite symposia

The second meeting in the EULAR 2008 Satellite Symposia will take place this evening. This prestige presentation offers a unique opportunity, not just to hear opinion leaders review the past achievements and current status of anti-TNF therapy, but also to present your own views and comments. We hope you will be able to attend.

Friday 13th June: 17.30 – 19.00, Amphi Havane, Palais des Congrès

Drawing on Experience to Shape the Future: 15 years of Anti-TNFs

An interactive, audience-driven meeting

- Opening Remarks
  Iain B. McInnes, MD, PhD, FRCP: *Centre for Rheumatic Diseases, University of Glasgow, United Kingdom*
- 15 Years – What Have We Learned?
  Georg Schett, MD: *University of Erlangen-Nuremburg, Erlangen, Germany*
- How Can We Shape Clinical Practice With Data?
  Ronald van Vollenhoven, MD, PhD: *Karolinska University Hospital, Stockholm, Sweden*
- Is Drug-free Remission an Achievable Goal?
  Bernard Combe, MD: *Hôpital Lapeyronie, Montpellier University Hospital, France*
- What Lies Ahead?
  Iain B. McInnes, MD, PhD, FRCP: *Centre for Rheumatic Diseases, University of Glasgow, United Kingdom*

We would like to thank everyone who attended the Thursday symposium and hope they found it both useful and interesting.

We look forward to seeing you on booth P36, level 01.

Our experience shapes brighter futures

Mediterranean Fever Has Lipid Profile Like RA

Not only Familial Mediterranean Fever patients but also their first-degree relatives, who likely carry the gene linked to the disease, experience serum lipid changes that resemble those seen in other chronic inflammatory diseases, such as rheumatoid arthritis and systemic lupus erythaematosus, according to the results of a study to be presented Friday.

"Although [Familial Mediterranean Fever, or] FMF patients are symptom-free between the attacks, subclinical inflammation continues during the attack-free period," Prof. Umut Kalyoncu of Hacettepe University Faculty of Medicine in Ankara (Turkey) told *EULAR Congress News* in an interview.

FMF is an autoinflammatory disease characterised by periodic attacks of fever and serositis. Symptoms include abdominal pain, pleuritis, and arthritis. FMF is a common disease in certain ethnic groups living around middle Asia. Its prevalence in Turkey has been reported as 1 in 1,073, though that number likely underestimates the frequency of the disease, said Prof. Kalyoncu.

More than 100 Mediterranean fever gene (MEFV) mutations that cause FMF have been identified; however, the absence of a MEFV mutation does not exclude the diagnosis of FMF. There are also healthy individuals who are completely asymptomatic but who carry the MEFV mutations, so the presence of MEFV mutations does not necessarily mean that an individual has FMF.

For the study, which will be presented by a colleague of Prof. Kalyoncu's, 63 patients with FMF were recruited (45 female), along with 30 first-degree relatives of FMF patients (20 female) and 59 healthy controls (40 female). Patients and relatives were excluded if they had a history of conditions that affect the lipid profile, such as endocrinopathies (diabetes mellitus, hypothyroidism), familial dyslipidaemia, liver or kidney disease, or other inflammatory diseases. In the patient group only, amyloidosis was also an exclusion criterion. Individuals taking medications that affect lipid metabolism and who had a body mass index (BMI) greater than 30 kg/m^2 were also excluded.

Blood samples of all subjects were obtained after an overnight fast. The researchers measured acute phase reactants, insulin, fasting glucose, apolipoprotein A, apolipoprotein B, total cholesterol, high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol, and triglyceride levels. Insulin resistance was determined by the homoeostasis model assessment (HOMA) index.

The mean age of FMF patients and controls was similar (30 years and 32 years, respectively). However, FMF relatives were older (38 years on average). There were no differences among groups with regard to gender, mean systolic and diastolic blood pressure, BMI, percentage of smokers, or fasting glucose, insulin, acute phase reactant, and HOMA index levels.

Serum lipid levels were similar between FMF patients and their relatives, with the exception of total cholesterol, which was significantly greater for FMF relatives—177 mg/dL for relatives, vs. 155 mg/dL for patients. Serum HDL-C levels were significantly lower in FMF patients and their relatives than in healthy controls—48 mg/dL and 49 mg/dL for patients and relatives respectively, vs. 59 mg/dL for controls. Patients with FMF and relatives had also lower apolipoprotein A levels than controls—121 mg/dL and 128 mg/dL for patients and relatives respectively, vs. 149 mg/dL for controls.

"In our study, we did not assess first-degree relatives of FMF patients for the presence of MEFV mutations. [However], FMF is an autosomal recessive disease. Therefore, asymptomatic first-degree relatives should have one of [the] MEFV mutations.

"On the other hand, mutations may occur spontaneously, and this may be taken as a limitation of our study," according to Prof. Kalyoncu.

Abstract Session:
Periodic Fever Syndromes: Take Two Aspirin, but You Still Call Me in the Morning ...
Friday, 10:15–11:45
Room Maillot

Varying Definitions Explain Remission Differences in RA

The definition of disease activity in rheumatoid arthritis (RA) appears to contribute to variability in remission rates as well as gender differences in RA disease activity, according to analyses from the multinational Questionnaires in Standard Monitoring of Patients with Rheumatoid Arthritis database. The data will be presented on Friday.

By April 2008, the QUEST-RA database included 6,004 patients receiving usual care at 70 sites in 25 countries. Participating rheumatologists completed a three-page clinical assessment while patients completed a four-page self-report questionnaire. On average, patients had RA for 11 years and were 57 years old; 79% were female.


Dr. Tuulikki Sokka

In an interview with *EULAR Congress News*, lead investigator Dr. Tuulikki Sokka explained that although remission is rare, it is the treatment goal of RA at this time. However, a single gold-standard measure for remission does not exist, and several composite scores of disease activity measures are applied to define remission. The traditional measure for remission is the ACR definition, which requires the absence of symptoms that are common in the elderly population, such as pain and fatigue. Therefore, remission rates according to the ACR definition are low, explained Dr. Sokka, senior researcher at Jyväskylä Central Hospital and Medcare Oy, Äänekoski, both in Finland.

In QUEST-RA, remission was calculated using different definitions. Only 9% of patients were in remission according to the ACR definition. On the other hand, 20% of patients were in remission according to the definition of remission on the Disease Activity Score–28 (less than 2.6). "DAS28 provides significantly higher rates of remission than the ACR definition. Thus, it is no wonder that DAS28 remission has been invariably used as a definition of remission in recent clinical trials of biologic agents. Remission rates in clinical trials and clinical studies should be interpreted according to the definition that has been used for remission," noted Dr. Sokka. Some recent studies suggest that women have more severe RA than do men. In QUEST-RA, Dr. Sokka and colleagues found that among the various disease activity measures, the number of swollen joints was more similar between women and men that were other disease measures. Therefore, the investigators compared other disease activity measures based on the number of swollen joints. They found that among patients only one or no swollen joints (indicating only minor or no disease activity), patient-reported impairment of function in daily activities and symptoms such as pain and fatigue were significantly higher for women than men, as were erythrocyte sedimentation rates and physician estimates of patient status. "It is possible that recent observations of gender differences in RA originate from the measures of disease activity rather than from RA disease activity itself," Dr. Sokka concluded.

Abstract Session:
RA—Clinical Aspects and Comorbidity
Friday, 10:15–11:45
Room Ternes

Methotrexate Efficacy Similar for PsA, RA

Methotrexate can reduce inflammatory joint activity and improve health-related quality of life in psoriatic arthritis, according to data to be presented on Saturday.

"Methotrexate is the most important DMARD [disease-modifying antirheumatic drug] in rheumatoid arthritis, and our results support that methotrexate is of similar importance also in psoriatic arthritis," Dr. Elisabeth Lie said in an interview.

Dr. Elisabeth Lie

Rigorous evidence to support use of methotrexate for psoriatic arthritis (PsA) is limited. Dr. Lie, of the department of rheumatology, Diakonhjemmet Hospital, Oslo (Norway), assessed 430 methotrexate-naïve adults with PsA enroled in the Norwegian DMARD registry. They compared outcomes with another 1,222 similar RA patients. Participants and clinicians rated changes in inflammatory joint activity and health-related quality of life after being on methotrexate monotherapy for 6 months. Women composed 71% of the RA group and 47% of the PsA group. In addition, 35% of the RA group (mean age, 57 years) and 26% of PsA patients (mean age, 49 years) had erosive disease at baseline. "Methotrexate is by far the most widely used DMARD for psoriatic arthritis in the NOR-DMARD register and also in Norway in general," Dr. Lie said. "Most patients are treated with methotrexate before TNF [tumour necrosis factor]–inhibitor treatment is considered. And a significant number of patients seem to achieve an important improvement in markers of inflammation as well as health-related quality of life."

RA patients reported a mean 13-point improvement in global visual analogue scale scores, compared with baseline, vs. 12 among PsA patients at 6 months or last observation. Joint pain visual analogue scores improved a mean 14 points in the RA group and 12 in the PsA group. Physical functioning scores improved 9 points on the Short Form-36 instrument among the RA patients and 7 among the PsA patients.

Assessor global improvements also were greater for the RA group: 19, compared with 14 for the PsA group. Other mean changes that favored the RA group were the erythrocyte sedimentation rate (10.1 mm/hour and 6.5 mm/hour, respectively) and improvements in C-reactive protein levels (10.5 mg/L and 5.7 mg/L). But after adjusting for age, gender, methotrexate doses, and baseline values, only body pain and fatigue scores improvements remained significantly better for the RA group. Pain scores improved 14 points on the SF-36 measure among RA patients, compared with 10.1 among the PsA patients. Fatigue visual analogue scale scores improved 4 in the RA group compared with a negligible change, 0.01, in the PsA group.

"This supports that methotrexate also is an important treatment opportunity for patients with PsA," Dr. Lie said.

Financial support for the register comes from Abbott Laboratories, Amgen Inc., Roche, Bristol-Myers Squibb Co., Wyeth, Aventis Pharmaceuticals Inc., MSD, Schering-Plough Corp./Centocor Inc., and the Norwegian Directorate for Health.

Clinical Science:
Current Management of Psoriatic Arthritis
Saturday, 12:00–13:30
Room Bagatelle

Common in SS

PAH *from page 1*

were women, had a mean age of 53 years and were followed for a mean of 41 months.

Pulmonary hypertension was found in 18 patients (incidence of 1.37 per 100 patient-years).

Of these 18 patients, 8 had pre–capillary-pulmonary hypertension identified by RHC, and 8 had post–capillary hypertension detected despite the absence of left heart dysfunction on echocardiography (incidence of 0.61 per 100 patient-years for both groups).

The remaining two patients had pulmonary hypertension resulting from severe interstitial lung disease, Dr. Hachulla noted.

The findings show that post–capillary-pulmonary hypertension is common in systemic sclerosis, which indicates that RHC is necessary to confirm pre-capillary PAH, he concluded.

Clinical Science:
Vascular Aspects of Systemic Sclerosis
Friday, 13:30–15:00
Room Bagatelle

Tocilizumab as Good as Other Biologics in Early RA

Tocilizumab's efficacy in early rheumatoid arthritis was comparable with that of other biologics, according to data to be presented Saturday morning.

Dr. Alten Rieke of the Schlosspark Klinik, Berlin (Germany), looked at pooled data from two international, double-blind, placebo-controlled, phase III trials known as OPTION and TOWARD, which both looked at the effect of tocilizumab in moderate to severe RA. Patients who were included in Dr. Rieke's analysis received tocilizumab in dosages of 8 mg/kg via intravenous infusion every 4 weeks, plus DMARDs (disease-modifying antirheumatic drugs), or placebo.

In all, 326 patients with RA for less than 2 years were evaluated based on American College of Rheumatology (ACR) criteria, disease activity score–28 (DAS28), and EULAR response. Of these, 202 received the active treatment regimen of tocilizumab plus DMARDs.

In the actively treated patients, 60% achieved a 20% reduction in symptoms on the ACR criteria; 40% achieved a 50% reduction; and 24% achieved a 70% reduction by week 24. In comparison, in the placebo group, a 20% reduction in the ACR criteria was achieved by only 27%; a 50% reduction was achieved by only 11% of controls; and a 70% reduction in the ACR criteria was achieved by only 2% of placebo patients, a highly significant difference.

On the DAS28, remission was reached by 38% tocilizumab-treated early RA patients by week 24 and by only 2% of patients receiving placebo, which was also highly significant. And on the EULAR response score, moderate to good improvements in RA symptoms were seen in 81% of tocilizumab-treated patients with early RA, vs. 38% of placebo-treated patients.

Serious infections were observed at a rate of 5.16 per 100 patient-years in the actively treated patients with early disease. ■

Clinical Science:
Safety of Non–Anti-TNF Biologics
Saturday, 08:45–10:15
Room Ternes

Rituximab Worked in Patients With Inadequate Response to Anti-TNF

Rituximab is more effective at reducing disease activity in rheumatoid arthritis patients who failed other anti–tumour necrosis factor biologic drugs than is simply switching to another anti-TNF, according to results to be presented Saturday.

"Rheumatologists may consider switching early to rituximab in RA patients who have persistent active disease despite treatment with anti-TNF agents," said the study's presenter, Dr. Axel Finckh, in an interview with *EULAR Congress News*.

Dr. Finckh, of Geneva University Hospital (Switzerland), looked at 300 patients with RA who were originally enroled in the SCQM-RA (Swiss Clinical Quality Management of Rheumatoid Arthritis) cohort, which is the national Swiss RA register. Overall, 65% had a prior failure of anti-TNF drugs due to ineffectiveness or to having an adverse event associated with the drug; these patients had switched either to rituximab (n = 101) or to another anti-TNF agent.

There was no significant difference between the two groups in age; disease activity or duration; rheumatoid factor positivity; or glucocorticoids or disease-modifying antirheumatic drug use.

According to Dr. Finckh, those patients who had failed anti-TNF treatment prior to the study due to ineffectiveness and who were taking rituximab at baseline had a significantly milder evolution of disease activity, versus those patients who had failed an anti-TNF agent prior to the study and simply switched to another anti-TNF agent by baseline (mean decrease in Disease Activity Score 28, –1.55 vs. –1.03, respectively). This finding confirmed the results of prior observational studies.

However, when the motive for switching was something other than ineffectiveness—for instance, an adverse event in association with the previous anti-TNF agent—Dr. Finckh said the evolution of disease activity between the rituximab and alternative anti-TNF groups was "unsurprisingly" the same (mean decrease in DAS28, –0.86 vs. –0.77, respectively).

Dr. Finckh disclosed that the study was partially supported by Roche Pharma. ■

Abstract Session:
B Cells and Beyond
Saturday, 08:45–10:15
Amphi Bleu

Ready for Boarding!

Please visit stand 44 to learn more about B cell therapy in RA.

Please join us at our Symposium

The journey to optimal RA treatment strategies: why and when to switch

Venue: Grand Amphi, Palais des Congrès, Paris

Date: Thursday 12th June 2008, 17:30–19:00

Roche

In AS, Link Between MRI Inflammation and Syndesmophyte Formation Not Robust

Most syndesmophytes develop without any sign of inflammation on MRI, even though the occurrence of inflammation at sites of syndesmophytes in patients with ankylosing spondylitis suggests that inflammatory processes may trigger the formation of the bony spinal outgrowths, according to data being presented by Prof. Désirée van der Heijde on Saturday.

In an effort to gain insight into the processes underlying syndesmophyte development in ankylosing spondylitis (AS), Prof. van der Heijde of Leiden (the Netherlands) University and colleagues analysed the relationship between inflammation visible on MRI and new syndesmophyte formation in vertebral units (VUs) in a subset of patients who participated in the ASSERT (Ankylosing Spondylitis Study for the Evaluation of Recombinant Inifliximab Therapy) trial.

Patients who enroled in the 24-week, randomised, controlled ASSERT trial and the 102-week open extension underwent MRI at baseline, at week 24, and at week 102, and spinal x-rays at baseline and at week 102. The MRIs were scored by two independent readers using the AS Spinal MRI Activity (ASspiMRI-a) scoring system, which assesses 23 VUs of the entire spine. The x-rays were scored by two independent readers using the Modified Stoke Ankylosing Spondylitis Spine Score (mSASSS), which assesses 24 sites of the cervical and lumbar spine, spanning 12 vertebral units, said Prof. van der Heijde.

For the current analysis, the investigators identified 2,004 VUs in 182 patients that were assessed both by ASspiMRI-a and mSASSS. Using a multilevel approach to adjust for within-patient correlation by vertebral unit level and reader and total ASspiMRI and total mSASSS at the patient level, they determined that more than 75% of new syndesmophytes occurred in VUs without MRI activity at baseline, and fewer than 15% of vertebral units with MRI activity at baseline developed syndesmophytes, according to Prof. van der Heijde.

"There was a slight preference to develop [syndesmophytes] in VUs with MRI activity versus those without MRI activity," she said, noting that the slightly increased probability remained statistically significant after adjustment for within-patient correlation and treatment.

The analysis also showed that growth of existing syndesmophytes at the VU level was not associated with MRI activity, and that at the patient level, MRI activity was not associated with change in mSASSS, said Prof. van der Heijde.

Despite the finding that MRI inflammation in a VU slightly increases the propensity to form a new syndesmophyte in the same VU, the observation that most syndesmophytes develop in vertebral units without any sign of MRI activity suggests that other, as-yet-unidentified factors likely trigger syndesmophyte formation and growth, Prof. van der Heijde said. ■

Clinical Science:
Inflammation and Imaging in AS: What Is New?
Saturday, 8:45–10:15
Amphi Bordeaux

Please Join EULAR in 2009 in Copenhagen

It is never too early to make your plans to join us for the 2009 EULAR Congress, to be held in Copenhagen from June 10 to 13. EULAR will offer rigorously screened presentations to keep you up to date on breakthroughs in rheumatoid and connective tissue diseases. In Copenhagen, you will have the time and ease to reconnect with your colleagues and forge new bonds over shared research interests and great food in one of the world's best cities. See you there!

Please visit booth P10 to learn more

In Fibromyalgia, it's the neurons that may need calming—not the patients

People with Fibromyalgia don't need to "calm down"—that's an outdated way of thinking. It's their neurons that may need calming. It is now believed that what Fibromyalgia patients are suffering from is a dysfunctional **hyperexcitability in pain processing**. It's called **central sensitization**, and it's the leading theory behind this condition.[1]

A dysfunction in sensory processing

Central sensitization is believed to cause a dysfunction in pain processing and generalized heightened pain sensitivity in Fibromyalgia patients.[1] Increased levels of excitatory neurotransmitters (for instance, glutamate and substance P) may contribute to neuronal hyperactivity and central sensitization.[2] It is thought that the result of this is hyperalgesia and allodynia.

A new definition of patients who need to "calm down"

The scientists at the forefront of Fibromyalgia research are leading us to a clearer understanding of this once-controversial condition, and as our understanding of Fibromyalgia becomes clearer, we can better manage the symptoms. So in the future, when we talk about the need for Fibromyalgia patients to "calm down," it's their hyperexcited neurons we'll be talking about.

At Pfizer, we're working together for a healthier world.

References: 1. Staud R. Biology and therapy of fibromyalgia: pain in fibromyalgia syndrome. *Arthritis Res Ther.* 2006;8:208-214. **2.** Burke A, Smyth EM, FitzGerald GA. Analgesic antipyretic agents. In: Brunton LL, Lazo JS, Parker KL, eds. *Goodman & Gilman's The Pharmacological Basis of Therapeutics.* 11th edition. New York: McGraw-Hill; 2006:681.

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June 2008

In High Doses, Gout Drugs Equally Effective

Gout patients have equal rates of success in attaining a serum urate concentration of 0.30 mmol/L or less—a value thought to predict good control of flares and a reduction of tophi—with either allopurinol or benzbromarone, as long as the doses are slightly higher than normal and based on serum urate values, according to the results of a randomised, open-label trial to be presented Friday.

Mr. Mattheus Reinders

"In this small study, tolerability is not affected by doubling the dosage in patients not reaching target levels," said study investigator Mattheus Reinders, a hospital pharmacist at the Atrium Medisch Centrum, Heerlen (the Netherlands).

The results of the study make it clear that there is no difference in efficacy between allopurinol and benzbromarone, when given in adequate doses, despite their different mechanisms of action. It also shows "allopurinol must be dosed higher than usually done in trials and in clinical practice [300 mg/day] to reach target serum levels," Mr. Reinders said in an interview.

Gout flares and tophi mostly occur in those body parts with the lowest temperature: the extremities. It is often said that serum urate (uric acid) concentration—a well-accepted biomarker for evaluation of gout treatment—must be lower than the solubility at 37 °C (0.42 mmol/L) for good treatment. But solubility drops dramatically with lower temperature, and so lower serum urate values are needed. A serum urate concentration of 0.30 mmol/L or lower has been shown to be adequate in previous research, Mr. Reinders said.

EULAR's evidence-based recommendations for gout advise titrating the allopurinol dosage according to the level of serum urate that is attained. There is a lack of information about this approach and the effects of the higher dosages of serum urate-lowering drugs that will be required to decrease serum urate in patients who are not reaching target levels. Many clinicians also are prescribing only a fixed dosage of allopurinol 300 mg/day, he said.

Therefore, Mr. Reinders and his coinvestigators randomised 55 patients with newly diagnosed gout in an open-label trial comparing the efficacy and tolerability of allopurinol and benzbromarone. Allopurinol began at a dosage of 300 mg/day and was increased to 600 mg/day if necessary, while benzbromarone started at 100 mg/day and could be increased to 200 mg/day.

The gout diagnosis was confirmed by microscopic evidence of urate crystals in punctate from synovial fluid or periarticular structures or presence of tophi. The patients were indicated for serum urate-lowering treatment if they had tophi or more than two gout attacks per year. None of the patients had relevant liver or renal disease, and none had previously received either medication. Mr. Reinders conducted the research when he was in training at the Medisch Centrum Leeuwarden, also in the Netherlands, which funded the study.

After 2 months of treatment, a significantly greater percentage of patients who took benzbromarone 100 mg/day reached the target serum urate concentration of 0.30 mmol/L (13 of 25 patients, or 52%) than did patients who took allopurinol 300 mg/day (8 of 30 patients, or 27%). After the investigators doubled the daily dosage of each drug in patients who had not met the treatment target, there was no significant difference in the total percentage of patients who had successful treatment with allopurinol (21 of 27, or 78%), compared with benzbromarone (18 of 23, or 78%).

Even before the dose increase, two patients stopped taking allopurinol and three stopped taking benzbromarone because of adverse drug reactions. No more adverse reactions occurred after the dosages were increased in nonresponders. ■

Abstract Session:
Gout and Metabolic Bone Disease
Friday, 10:15–11:45
Room Bagatelle

Etanercept Eased Disk-Herniated Sciatica Pain

Caudal epidural injection with the tumour necrosis factor-alpha antagonist etanercept provides safe and effective pain relief in patients with disk-herniated sciatica, data from a new study have shown. Dr. Kensuke Kume of Hiroshima (Japan) Clinic will present the findings on Saturday.

Tumour necrosis factor-alpha (TNF-alpha) has been implicated as a major contributing factor in the development of radiculopathy in patients with disk-herniated sciatica. Based on the results of open-label and case studies, which have shown that TNF-alpha inhibition can alter the acute pain behaviour associated with the condition, Dr. Kume and his colleagues sought to assess the efficacy of caudal epidural TNF-alpha blockade with etanercept in a randomised controlled trial.

The trial included 28 patients with unilateral acute severe sciatic pain with an MRI-confirmed disk herniation and associated symptoms and signs of radicular pain. They were randomised to a single caudal epidural injection, guided by fluoroscopy, of either 25mg of etanercept or placebo. All of the patients were candidates for diskectomy, as evaluated by two independent orthopaedic surgeons, said Dr. Kume. Baseline and post-injection assessments for the first follow-up month included clinical examination with straight leg–raising test as well as questionnaires regarding subjective leg and back pain, diskectomies, and treatment-related adverse events. The study's primary end point was reduction in leg pain from baseline to one week, analysed using a Mann-Whitney U test and repeated-measures analysis.

Both the treatment and placebo groups reported a significant reduction in pain at day 1, with pain scores on the visual analog scale (VAS) for etanercept significantly reduced, compared with placebo, said Dr. Kume. Specifically, the respective mean baseline and day 1 pain scores on the VAS were 80.3 and 45.6 for etanercept and 78.0 and 58.2 for placebo.

At 1 month postinjection, both groups showed a significant reduction in pain with no significant difference between treatment regimens, said Dr. Kume, noting that the mean VAS pain scores were 32.6 for etanercept and 33.4 for placebo.

No treatment-related adverse effects were reported in either group within 1 month of the injection, he said. With respect to surgery, 5 patients in the etanercept group and 4 patients in the placebo group required diskectomies during the study period. According to Dr. Kume, the findings of this study suggest that epidural injection of etanercept is safe in patients with disk herniation–induced sciatica and has the potential to induce quick recovery from acute severe pain associated with the condition. ■

Clinical Science:
Disk Herniation: From Bench to Bedside
Saturday, 8:45–10:15
Room Monceau

Museums and Medicine: A Journey Into the Parisian Past

The first school of medicine in Paris was founded around the turn of the 12th century, and medicine has thrived in the city ever since, from some of the earliest medieval hospitals to the heyday of the modern Pasteur Institute. This remarkable history is on view in several museums in the heart of Paris.

Two sites of note are the Museum of the History of Medicine (Le Musée d'Histoire de la Médecine) at René Descartes University and the Orfila Museum of Anatomy (Musée d'Anatomie Delmas-Orfila-Rouvière) in Saint-Germain-des-Prés.

The Museum of the History of Medicine, founded in 1803, has some of the oldest medical collections in Europe, covering various branches of surgery up to the late 19th century. It displays physicians' kits and authentic examples of various medical instruments used over the centuries.

Many of the artifacts are as elegantly presented as fine art.

One of the most celebrated items in the collection is the anatomical dummy made in 1796 by physiologist Felice Fontana at the command of Napoleon Bonaparte. The dummy, made of poplar wood, consists of more than 2,000 removable components and was used to teach anatomy to physicians and surgeons.

Paintings, engravings, and lithographs, as well as over 1,600 autographs and photographs, are integral to the collection, which also includes over 800 volumes from the libraries of physicians and surgeons who lived during the 18th and 19th centuries.

The Museum of the History of Medicine is located at the university on the second floor of the former faculty of medicine building at 12, Rue de l'Ecole de Médecine, 75006 Paris. Hours are 14:00 to 17:30 except Thursday, Sunday, and holidays

Le Musée d'Histoire de la Médecine

(www.bium.univ-paris5.fr/musee/debut.htm). The fee is EUR 3,50.

The Ofila Museum of Anatomy showcases 18th- and 19th-century antique reproductions and displays of comparative anatomy from reptiles to humans. Among its collections are casts of the heads of criminals executed in the 19th century and brain casts, including that of the famous brain anatomist Paul Broca.

Collections of skulls, preserved specimens, mummified humans and lower animals, and plaster replicas obtained over the past 200 years also are on display. The Orfila Museum of Anatomy is on the eighth floor of the Faculté de Médecine at 45, Rue des Saints-Pères, 75006 Paris. Hours by appointment (www.biomedicale.univ-paris5.fr/anat/spip.php?article37).

This cytokine fuels the chronic joint and body inflammation associated with RA.

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CHUGAI

Abnormal Menstrual Cycles Are Common in Juvenile Lupus

Menstrual abnormalities after menarche were significantly more common in girls with juvenile systemic lupus erythaematosus, compared with healthy controls, based on data from 60 adolescent girls to be presented Saturday.

"This finding suggests a reduced ovarian reserve, since all patients and controls were in the same pattern of puberty," Prof. Clovis Silva said in an interview with *EULAR Congress News*.

Previous studies have shown delayed menarche in girls with juvenile systemic lupus erythaematosus (JSLE), but few have looked at the menstrual cycle after menarche concomitantly with hormonal status in girls with JSLE, versus healthy controls.

In this study, Prof. Silva, of the Faculdade de Medicina da Universidade de São Paulo (Brazil), compared the menstrual cycles and hormone levels in 30 girls with JSLE and 30 age-matched healthy controls. The average age in both groups was 17 years. Girls' average age at menarche was significantly older in the JSLE patients, compared with the controls (13.13 years vs. 11.56 years), but the average age of maternal menarche was similar for both groups (12.5 years vs. 13.2 years).

The researchers defined a normal menstrual cycle as lasting from 25 to 35 days with 3 to 7 days of blood flow. Menstrual cycles and hormone levels were monitored for at least 6 consecutive months.

Overall, significantly more JSLE patients had longer-than-normal cycles, compared with controls (63% vs. 10%). The median level of follicle-stimulating hormone was significantly higher in the JSLE patients, compared with controls (4.6 IU/L vs. 3.4 IU/L), but the median level of progesterone was lower (32.5 ng/mL vs. 70 ng/mL).

Among the 30 JSLE patients, the median level of luteinising hormone was significantly lower in those with abnormal menstrual cycles, compared with those with normal menstrual cycles (2.9 IU/L vs. 5.5 IU/L).

The JSLE patients with both abnormal and normal cycles were also very likely to have decreased progesterone levels (63% vs. 73%). Clinical disease findings were similar in the JSLE patients with normal and abnormal menstrual cycles.

The researchers found that the follicular ovarian reserve seemed to be low in the JSLE patients regardless of intravenous cyclophosphamide treatment, although none of them showed signs of premature ovarian failure.

Abstract Session:
Rheumatoid Disease in Adolescence
Saturday, 12:00–13:30
Amphi Havane

Friday, 13 June

Schedule Continued from page 1

Meet the Standing Committee
AHP: The teach-the-teachers course — Room Passy
PARE: Working in partnership with industry: Finding a healthy match — Room 253

13:30–15:00

State-of-the-Art/Best Practise
Management of cardiovascular risk in inflammatory disorders — Grand Amphi

Clinical Science
Young patients with old knees: treatment and prevention of knee osteoarthritis in the young — Room Ternes
Male osteoporosis — Amphi Bleu
Vascular aspects of systemic sclerosis — Room Bagatelle
Update on Sjögren's syndrome — Room Monceau

Challenges in Clinical Practise
Difficult clinical cases in RA — Amphi Bordeaux

Outcomes Science
Imaging and outcome measures in rheumatoid arthritis and spondyloarthritis — Room Maillot

Int'l Forum Young Rheumatologists
TLR-S in the pathogenesis of autoimmune diseases — Amphi Havane

Joint Clinical/AHP/PARE Session
Pregnancy and arthritis health care — Room 252-AB

Translational/Basic Science
Treatment of rheumatic diseases in the future: novel strategies — Room 342-AB
Microparticles: new mediators of intercellular communication — Room 352-AB

Practical Skills
Ultrasound 2: Learning and using US now and in the future — Room 241

Allied Health Professionals Workshop
Writing for publication, including how to carry out a literature search, write an abstract and write for publication — Room Passy

15:30-17:00

State-of-the-Art/Best Practise
Polymyalgia rheumatica and giant cell arteritis — Grand Amphi

Clinical Science
Inflammatory myopathies — Room Ternes
EULAR–EFORT session: Management of the acute swollen knee — Amphi Bleu
Lymphomas and autoimmune diseases — Room Bagatelle
Complex management issues in osteoarthritis — Amphi Bordeaux
Musculoskeletal ultrasound in inflammatory arthritis — Room Monceau

Outcomes Science
What is the contribution of trauma to the cause of rheumatic diseases? — Room Maillot

PRES Session
Mind the gap: The cost and consequences of rheumatic disease in adolescence — Amphi Havane

Joint Clinical/AHP/PARE
Patient partnerships: Could we do better? — Room 252-AB

Translational/Basic Science
Genes, environment in RA — Room 342-AB
Pathogenesis of osteoarthritis: Novel mechanisms — Room 352-AB

Meet the Standing Committee
Lupus, vasculitis, stem cells, steroids — Room Passy

Practical Skills
MRI in inflammatory joint diseases 2 (50 Part.) — Room 353

Saturday, 14 June

Registration 08:00–15:30
Exhibition 09:30–15:00
Scientific Sessions 08:45–14:45
Farewell Drink at le Palais des Congrès 17:00

08:45–10:15

State-of-the-Art/Best Practise
Drug-induced osteoporosis — Grand Amphi

Clinical Science
Safety of non anti-TNF biologics — Room Ternes
Amyloidosis and autoinflammatory disorders — Room Bagatelle
Inflammation and imaging in AS: What is new? — Amphi Bordeaux
Disk herniation (from bench to bedside) — Room Monceau

Abstract
B cells and beyond — Amphi Bleu

Outcomes Science
Men and women: Accounting for differences in inflammatory rheumatic diseases — Room Maillot

Fellows in Training
Immunity explained — Amphi Havane

Translational/Basic Science
T-Reg and beyond — Room 342-AB
Pain pathways and neuroinflammation: Therapeutic strategy — Room 352-AB

Allied Health Professionals
Multidisciplinary care and research demonstrated by systemic sclerosis — Room Passy

10:15–11:45

PARE Workshop
Patient participation in the development of recommendations (part 1) — Room 253

12:00–13:30

State-of-the-Art/Best Practise
Fibromyalgia — Grand Amphi

Clinical Science
Clinical approach to early inflammatory arthritis — Room Ternes
Evidence based approach to shoulder pain syndromes — Amphi Bleu
Current management of psoriatic arthritis — Room Bagatelle

Outcomes Science
Rheumatological interventions: Better value than other specialties? — Room Maillot

Abstract
Rheumatoid disease in adolescence — Amphi Havane

Translational/Basic Science
T inflammatory cells: Th17 — Room 342-AB
cellular therapy of autoimmune disease — Room 352-AB

Allied Health Professionals
Promoting exercise and physical activity in patients with rheumatic diseases: How to begin? — Room Passy

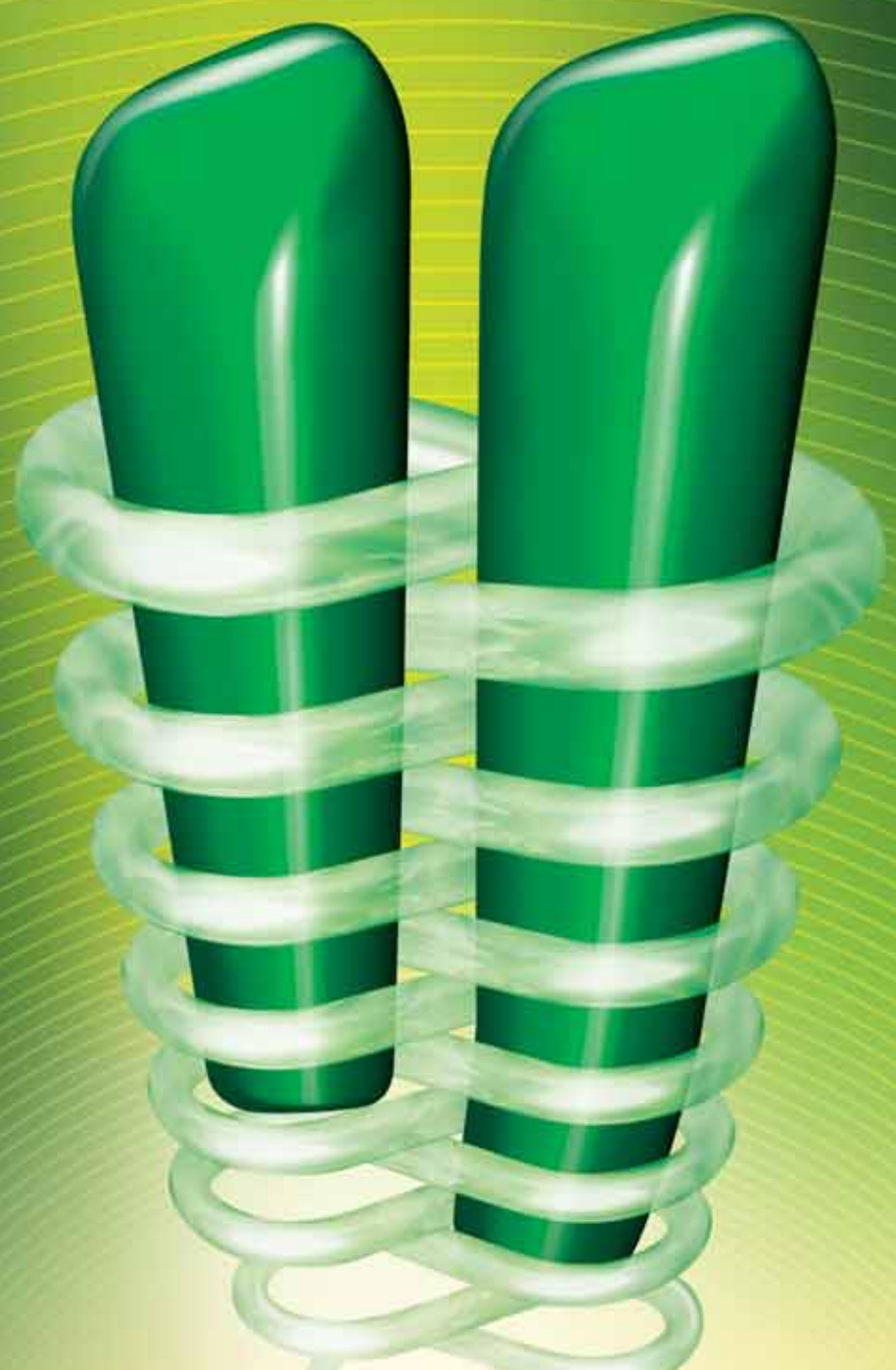
PARE Workshop
Patient participation in the development of recommendations (part 2) — Room 253

13:45–14:45

Clinical Science
Highlights: Clinical and basic science — Room Ternes

Allied Health Professionals
Highlights of the AHP programme 2008 — Room Passy

PARE
PARE highlight session — Room 253



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Visit booth M16.

Satellite Programme

Friday, 13 June 2008

08:15–09:45
Wyeth Pharmaceuticals
Room Ternes
Value in RA Management
Chairman: R. van Vollenhoven, Sweden

08:15–08:20
Welcome and introduction
R. van Vollenhoven, Sweden

08:20–08:45
Value and 21st century medicine
B. Jönsson, Sweden

08:45–09:10
The value of early intervention in RA
F. Breedveld, Netherlands

09:10–09:35
Real-life usage of biologics
R. Moots, UK

09:35–09:45
Chairman's close
R. van Vollenhoven, Sweden

08:15–09:45
IBSA-Genévrier
Amphi Bleu
Educational Efforts in the Management of Osteoarthritis
Chairmen: J.-Y. Reginster, Belgium
A. Kahan, France

08:15–08:20
Welcome and introduction
A. Kahan, France

08:20–08:40
The importance of patient's education in osteoarthritis management
L. Euller-Ziegler, France

08:40–08:55
Past and new approaches for knee JSN measurements
P. Delmas, France

08:55–09:10
STOPP: New update
A. Kahan, France

09:10–09:20
Basic statistical principles in meta-analysis studies
F. de Vathaire, France

09:20–09:35
Chondroitin sulfate: The first complete meta-analysis based on raw data
D. Uebelhart, Switzerland

09:35–09:45
Discussion and conclusion: meta-analysis studies
J.-Y. Reginster, Belgium

08:15–09:45
Pfizer
Amphi Bordeaux
The Evolving Benefit-Risk Balance of NSAID Therapies—An Update for Rheumatologists
Chairman: T. Kvien, Norway

08:15–08:25
Introduction
T. Kvien, Norway

08:25–09:00
Gastrointestinal risk evaluation in rheumatology practise
F. Chan, Hong Kong

09:00–09:35
Understanding and communicating benefit-risk in chronic anti-inflammatory therapy
A. Moore, UK

09:35–09:45
Questions
T. Kvien, Norway

08:15–09:45
NicOx
Amphi Havane
New Insights in the Role of Nitric Oxide for the Management of OA
Chairman: F. Berenbaum, France

08:15–08:35
Introduction
New horizons in the treatment of OA
F. Berenbaum, France

08:35–08:55
Nitric oxide in inflammation and pain
S. Abramson, USA

08:55–09:15
Nitric oxide and cardiovascular effects
T. MacDonald, Scotland

09:15–09:35
Role of nitric oxide in the gastrointestinal tract
A. Lanas, Spain

09:35–09:45
Panel discussion/Q&A
All Faculty

08:15–09:45
Ipsen
Room Maillot
Can We Make Gout Crystal Clear?
Chairmen: T. Bardin, France
M. Doherty, UK

08:15–08:20
Welcome and introduction
M. Doherty, UK

8:20–08:40
Insights into the inflammatory process of a gout flare
A. So, Switzerland

08:40–09:00
Treating to target: a strategy to cure gout
F. Perez-Ruiz, Spain

09:00–09:20
Febuxostat: a new treatment for hyperuricaemia in gout
L. Edwards, USA

09:20–09:40
Panel discussion
T. Bardin, France
M. Doherty, UK

09:40–09:45
Closing remarks
T. Bardin, France

17:30–19:00
Abbott Laboratories
Grand Amphi
Can We Improve Outcomes by Treating to Target in Rheumatoid Arthritis and Spondyloarthritis?
Chairman: J. Smolen, Austria

17:30–17:40
Welcome and introduction
J. Smolen, Austria

17:40–17:55
What can be achieved in 2008 for rheumatoid arthritis patients?
F. Breedveld, Netherlands

17:55–18:10
What should the target in rheumatoid arthritis be? Why is targeted treatment necessary?
J. Smolen, Austria

18:10–18:20
Rheumatoid arthritis—challenges and prospects
J. Smolen, Austria
F. Breedveld, Netherlands

18:20–18:40
What is the treatment target for spondyloarthritis?
M. Dougados, France

18:40–18:55
Panel discussion and Q&A
All

18:55–19:00
Closing remarks
J. Smolen, Austria

17:30–19:00
Servier
Amphi Bleu
Management of Osteoporosis: A Physiological Answer for a Living Tissue
Chairmen: P. Delmas, France
C. Roux, France

17:30–17:35
Introduction
C. Roux, France

17:35–17:55
Bone throughout human life
E. Seeman, Australia

17:55–18:15
New bone imaging techniques: from research to bedside outcomes
H. Genant, USA

18:15–18:35
Rebalancing bone turnover in favor of formation: implications for bone strength
J.E. Fonseca, Portugal

18:35–18:55
Strontium ranelate: short- and long-term benefits for osteoporotic patients
C. Roux, France

18:55–19:00
Conclusion
P. Delmas, France

17:30–19:00
Actelion Pharmaceuticals
Amphi Bordeaux
Examining the Evidence in Systemic Sclerosis
Chairmen: L. Guillevin, France
A. Tyndall, Switzerland

17:30–17:45
EULAR/EUSTAR recommendations: achievements in SSc
A. Tyndall, Switzerland

17:45–18:00
Vasculopathy: A cardinal feature of SSc
L. Guillevin, France

18:00–18:20
Digital ulcers: Applying the evidence
M. Matucci Cerinic, Italy

18:20–18:40
PAH-SSc: The impact of early intervention
M. Humbert, France

18:40–19:00
Panel discussion: Applying recommendations in clinical practise
All

17:30–19:00
Schering-Plough Pharmaceuticals
Amphi Havane
Drawing on Experience to Shape the Future: 15 Years of Anti-TNFs (An Interactive Audience-Driven Session)
Chairman: I. McInnes, UK

Opening remarks
I. McInnes, UK

15 years: What have we learned?
G. Schett, Germany

How can we shape clinical practise with data?
R. van Vollenhoven, Sweden

Is drug-free remission an achievable goal?
B. Combe, France

What lies ahead?
I. McInnes, UK

17:30–19:00
Pierre Fabre Médicaments
Room Maillot
Fibromyalgia—From Symptoms to the Disease: Report of the 5th Entretien du Carla
Chairman: J. Costa e Silva, Brazil

17:30–17:40
Introduction
J. Costa e Silva, Brasil

17:40–18:00
The patient: Specificities and risk factors
R. Gracely, USA

18:00–18:20
Diagnosis and co-morbidity
J. Winfield, USA

18:20–18:40
Therapeutic advances
P. Sarzi Puttini, Italy

18:40–19:00
What to do when faced with FM patients
D. Buskila, Israël

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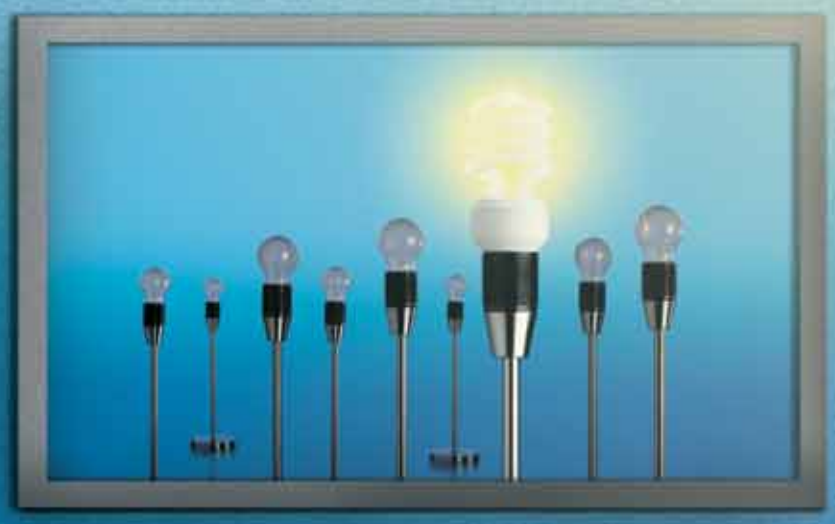

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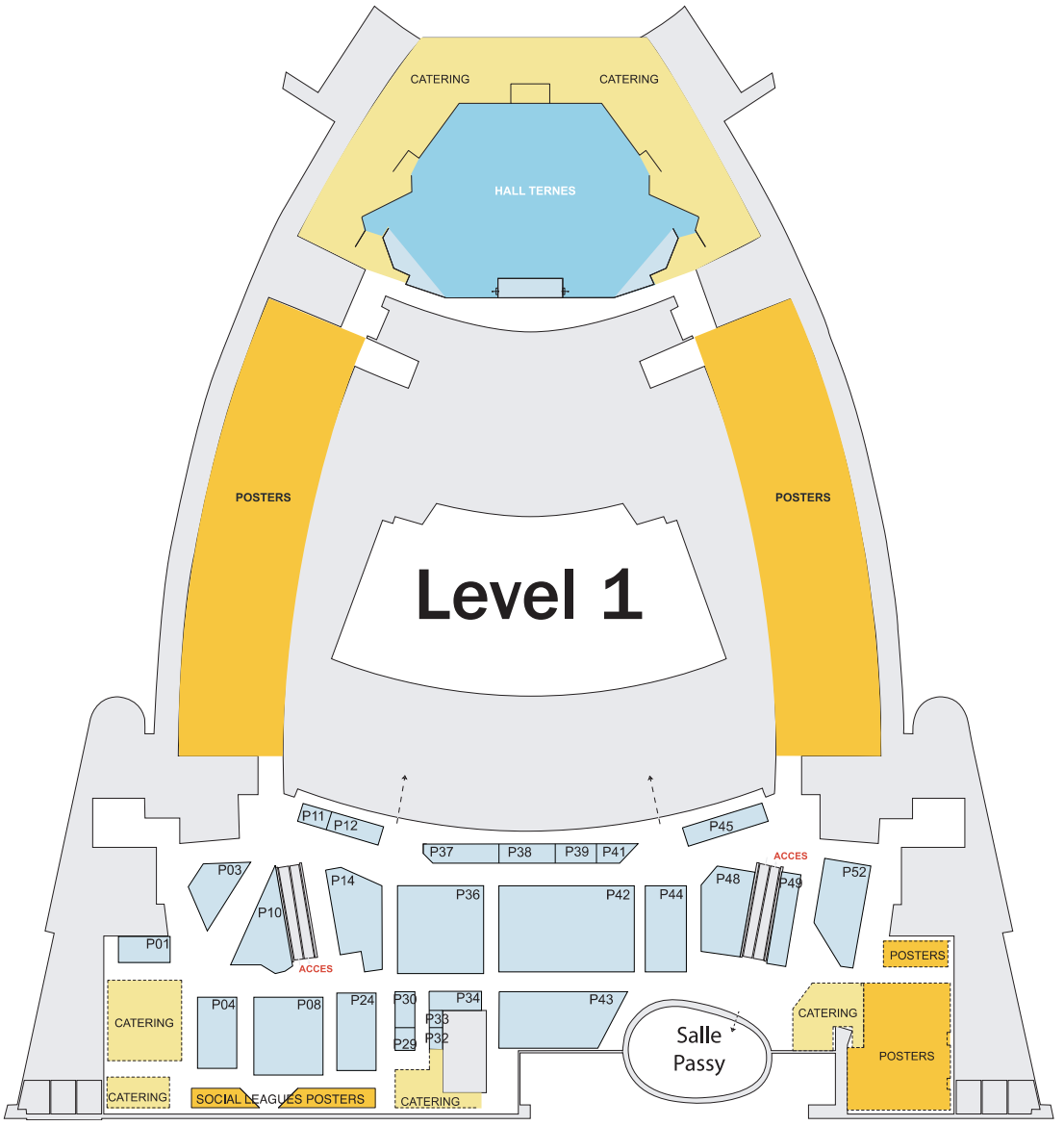

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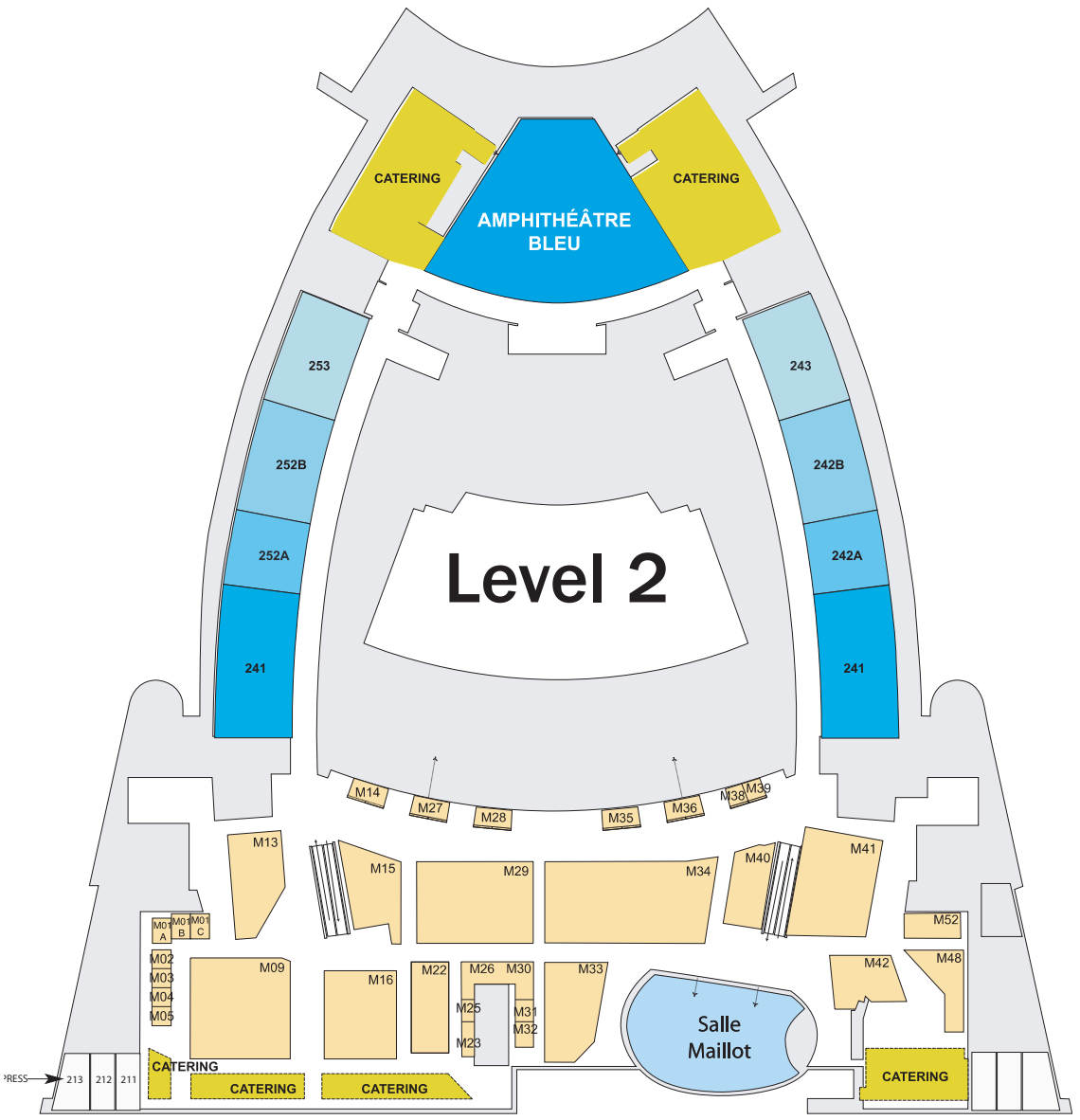

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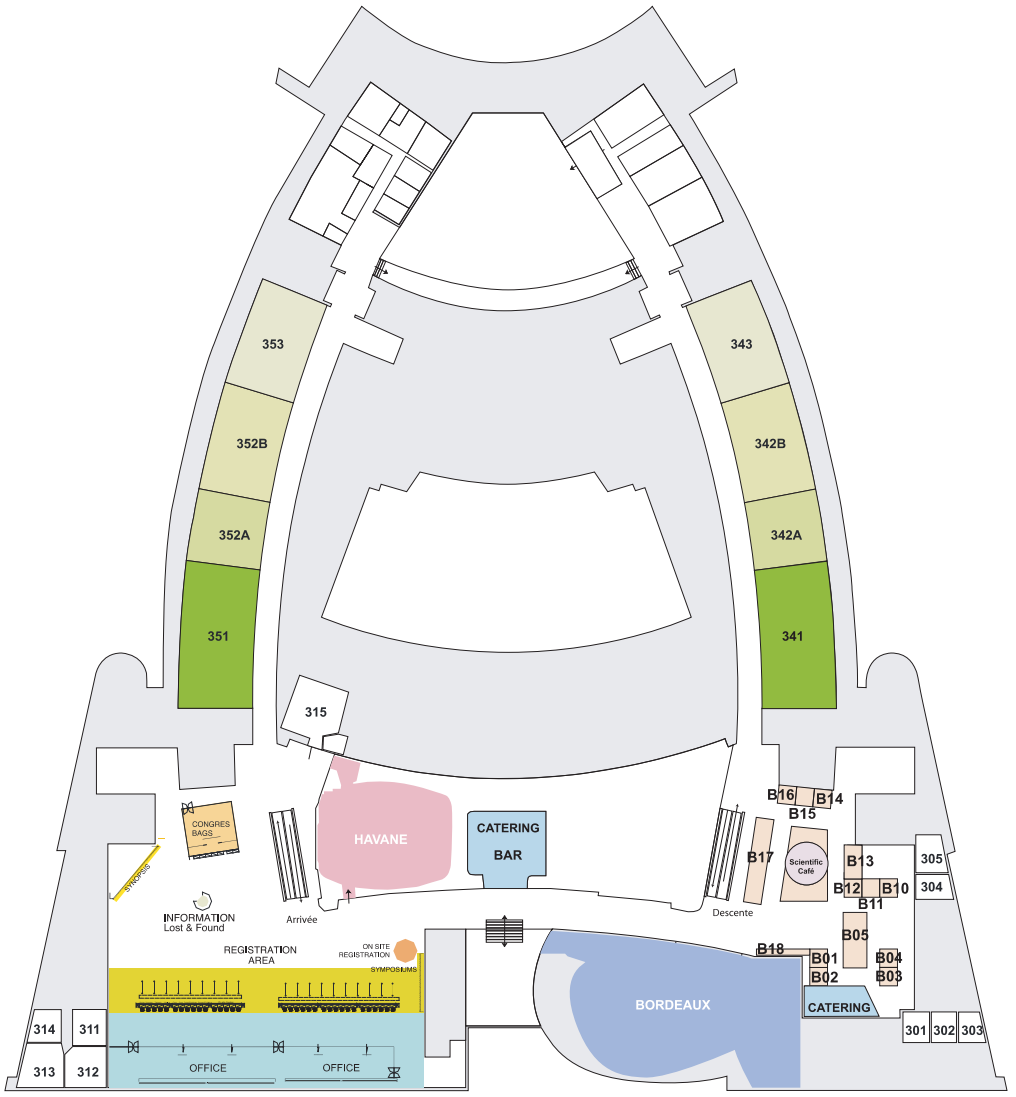

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B16 THE LONDON LUPUS CENTER
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B18 WISEPRESS ONLINE BOOKSHOP

Excursions Offer Escape and Experiences

Paris is a challenging city to get to know on your own in a few days. Please let an excursion show you some of this beautiful city's surprises and delights. A tour programme is provided below. You may sign up for tours online or at the Congress.

Palace of Versailles

After his marriage, Louis XIV undertook a project to enlarge the château at Versailles, which had been built by Louis XIII as a hunting lodge, to a royal palace. The project was never truly finished. Today, two châteaux stand on the site: the older, smaller one built by Louis XIII and the larger one designed to suit Louis XIV, whose royal family and court resided here

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along with numerous traders and artisans. Under Louis XIV, Versailles became the centre of France, which revolved around its Sun King. A visit to the royal apartments retraces this sumptuous period in French history. The Hall of Mirrors, in which the Treaty of Versailles was signed, was used for large receptions when Louis XIV wanted to impress guests. Your visit will conclude with a visit to Marie-Antoinette's private apartments.
Friday, 13 June 2008, 14:00-18:00
Price per person: EUR 57

Cooking School: Le Cordon Bleu

French cooking is world famous. In addition to talented amateur chefs who cook for the pleasure of their family and friends, many cooking schools perpetuate the art of French cooking. Greatest among them is

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the École Cordon Bleu. As part of your visit to the school, a chef will prepare a multicourse meal for your enjoyment and will answer your questions. The full lists of ingredients for the various recipes will be provided, and at the end of the demonstration you can taste the different dishes.
Friday, 13 June 2008, 08:30-12:00
Price per person: EUR 70 *(Transportation by Métro)*

Eiffel Tower and Cruise on the Seine

The Seine has always been the heart and soul of Paris. The city first formed along its banks. This 1-hour cruise on a bateau mouche will allow you to see many of Paris's oldest and most majestic monuments—among them the Cathedral of Notre Dame, the Musée d'Orsay, the Hôtel des Invalides, and the Grand Palais, as well as the bridges that span the Seine—from the unique perspective of the river. Disembarking at the Eiffel Tower, you will take its hydraulic lift to the second level for a walk around the platform, from which you can enjoy the different sights and have an extensive view of Paris and its outskirts.

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Saturday, 14 June 2008, 09:00-13:00
Price per person: EUR 48 *(Transportation by Métro)*

Reims and the Champagne Region

Enjoy a drive to Reims, which is both the capital city of the Champagne region and the "city of coronations." An orientation tour of Reims, including a guided visit to the Gothic cathedral where most of the kings of France were crowned, will be followed by a carriage tour of the Piper-Heidsieck champagne cellars. After lunch in Reims, we will visit Épernay and the prestigious wine cellars of Moët & Chandon. (Depending on availability, tours of other famous champagne cellars may be substituted.)

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Saturday, 14 June 2008, 08:30-17:00
Price per person: EUR 130 *(including lunch)*

The EULAR Congress News
The Official Newspaper of the 9th Annual European Congress of Rheumatology

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EU Declares Rheumatic Diseases a Priority

This year, EULAR has opened a new office in Brussels, the capital of the European Union.

For the past several years, EULAR has represented the political interests of the rheumatic disease community at the EU level and beyond. As part of that effort, EULAR has created the Alliance Against Arthritis (AAA), which holds annual meetings in Brussels. The meeting provides a venue for patients and rheumatology experts to interact with members of the cabinets and directorates general of the Research, Health and Employment Commissioners, making them consistently aware of the importance of rheumatic diseases as well as their health and economic burden on society. Rheumatic diseases are the leading cause of sick leave and early retirement and elicit highest direct and indirect costs of any disease group.

Owing to EULAR's efforts, rheumatic diseases were declared a priority by the European Parliament in two declarations in 2005 and 2008. The latest written declaration, receiving the required number of signatures by members of the EU Parliament, calls for the following:

The European Parliament, having regard to Rule 116 of its Rules of Procedure

A. Whereas rheumatic diseases are chronic complaints which cause pain, suffering and disability,

B. Whereas 30%-40% of people have musculoskeletal symptoms, and whereas such symptoms affect more than 100 million people in Europe,

C. Whereas rheumatic diseases represent the main cause of disability and premature retirement among workers,

D. Whereas it is estimated that people over 65 will account for up to one-quarter of the European population by 2030, and whereas a majority of people over 70 present with chronic or recurrent rheumatic symptoms,

E. Whereas the adoption of social and health policies based on an analysis of the needs of those with rheumatic diseases would reduce the economic and social costs associated with these diseases (1-1.5% of GNI in developed countries),

1. Calls on the Commission and the Council to:

- ▶ attach more importance to rheumatic diseases in the new community strategy on health, given their high social and economic costs.
- ▶ encourage member states to establish and promote the implementation of national plans to fight rheumatic diseases.
- ▶ develop a community strategy on rheumatic diseases and draw up a council recommendation on the early diagnosis and treatment of rheumatic diseases.
- ▶ develop a strategy to improve access to information and medical treatment.

2. Instructs its president to forward this declaration, together with the names of the signatories, to the council, the commission, and the parliaments of the member states.

EULAR has also actively engaged in influencing the European Union to include rheumatic diseases in the European Union's 7th Research Framework Programme (FP7), and several grants have meanwhile been awarded to rheumatic disease research. However, despite the rank of rheumatic diseases in terms of health burden and costs, EU politicians still refuse to grant rheumatic diseases the full recognition of being a "major disease" group with separate funding streams, as has been granted for several other areas. Moreover, the third call of FP7 did not contain programs for rheumatic diseases-an incredible neglect by the EU.

Since the needs of rheumatic disease research are still partly ignored by European politicians, EULAR will continue struggling for better research support as well as for high standards in diagnosis, treatment, and care. Likewise, disability legislation does not yet sufficiently account for the physical impairment of people with musculoskeletal conditions and access to best care is not yet guaranteed across the European Union.

While the community will soon develop a strategy on rheumatic diseases and draw up a council recommendation on their early diagnosis and treatment, EULAR and various European centers of excellence will put together respective proposals for these aspects. With the progresses revealed at every Annual European Congress of Rheumatology and the new EULAR office in Brussels, the European rheumatology community will soon overcome the barriers inhibiting optimal development, for the sake of people with rheumatic diseases.

Prof. Josef S. Smolen
EULAR Liason Officer, International Organisations

Faces of EULAR

Dr. Nicole Fahlman, from Calgary, Canada, is an adult rheumatologist at the University of Calgary. She works in a clinic with

one of three paediatric rheumatologists at the University and is also interested in inflammatory arthritis, psoriatic arthritis and juvenile arthritis. She plans to attend presentations in those areas at the Congress, she said. This is her first visit to Paris as well as her first EULAR Congress. To make the most of these two opportunities, she'll be trying to attend as many symposia and see as many sights as she can. "It's going to depend on how much time I have!"

Prof. Johanne Martel-Pelletier, Ph.D., and **Dr. Jean-Pierre Pelletier** are from Montréal, Canada, and both are on the faculty of the University of Montréal. The couple both specialize in osteoarthritis and will be lecturers at this year's Congress, as they have done in the past. The two have been to the EULAR Congress many times before and have also travelled many times to Paris. "I like small museums," she said. They are looking forward to visiting the Musée de Montmartre and the Musée d'Orsay.

Dr. Javier Basualdo, from Santiago, Chile, is from the University of Chile. Dr. Basualdo attended the Congress last year

when it was held in Barcelona. This year, he spent a week in Brussels, Belgium before coming to Paris. Dr. Basualdo specializes in Sjögren's Syndrome, vasculitis, osteoporosis, and arthritis and is looking forward to abstract sessions and posters on those topics.

Prof. Michael Ausserwinkler, is from Althofen, a small town in Austria. He works at a research centre there that is affiliated with the University of Vienna. He is a EULAR Congress veteran—this is his 9th Congress. "I am very pleased because the program has a variety of outstanding topics, giving me the problem of how to choose the right session!"

Claire Jeffries, from Portsmouth, England, is a chartered physiotherapist and a team leader of rheumatology and hydrotherapy at a small clinic within the National Health Service. Her specialty is ankylosing spondylitis. "There are some good intensive lectures on it this year," she said. She's attended the last two Congresses in Amsterdam and Barcelona. She and her colleagues are looking forward to "getting updated on what the other Allied Health Professionals are doing," she said. "We took a trip to the Sacré-Cœur yesterday afternoon. It was lovely."

Dr. Djamel Hadjoudj is from Fontainebleau, France, where he practices rheumatology at the Hôpital de Fontainebleau. He attends EULAR to stay up to date with new recommendations and also to meet new people in the field: "C'est important."

Dr. Alfred Kim is attending EULAR this year with **Elvit Zubiri, R.N.** Dr. Kim is a fellow at the Washington University in St. Louis, U.S.A. He is looking forward to attending some of the basic science sessions, especially on the topics of T regulatory cells, Th17, inflammasomes, gene therapy and microparticles. This Congress is his first, and this is his first time in Paris. What is he looking forward to in the City of Light? "Basically everything," he said. "We've had a lot of champagne."

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TODAY

Can we improve outcomes by TREATING TO TARGET in rheumatoid arthritis and spondyloarthritis?

SATELLITE SYMPOSIUM

Friday 13 June, 17:30-19:00 • Grand Amphi, Le Palais des Congrès de Paris

Chair
Josef Smolen, MD
Professor of Internal Medicine,
Medical University of Vienna
and Hietzing Hospital,
Vienna, Austria

Speakers
Ferdinand Breedveld, MD
Professor of Rheumatology,
Leiden University Medical Centre,
Leiden, The Netherlands

Maxime Dougados, MD
Professor of Rheumatology,
Hospital Cochin,
Paris, France

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